



Lytle Veterinary
Clinic, Inc.

Your Pet's Medical Information & History

Owners Name	Pet's Name
Account#	Date

Reason for today's visit: _____

INSTRUCTIONS: Please Circle Yes or No (Explain on line if needed)

Has your address, home or work telephone numbers changed since your last visit? **Yes No**
If so, please write any changes on the line below.

Has your pet had any recent medical problems?	Yes No	_____
Does your pet have any chronic medical problems?	Yes No	_____
Does your pet have any allergies? (If yes, to what?)	Yes No	_____
Is your pet on any medications? (If yes, what?)	Yes No	_____
Has your pet traveled out of state? (If yes, where?)	Yes No	_____
Was your pet heartworm tested within the last year?	Yes No	_____
Is your pet given heartworm prevention medication?	Yes No	_____
Has your pet been tested for worms in the last year?	Yes No	_____
Is your DOG vaccinated against Lyme Disease ?	Yes No	_____

Has your pet shown any of the following **signs or symptoms**?

Bad breath or unusual body odors?	Yes No	Head shaking?	Yes No
Coughing or sneezing or wheezing?	Yes No	Itching or scratching?	Yes No
Gagging or choking?	Yes No	Poor coat or hair loss?	Yes No
Vomiting or diarrhea?	Yes No	Skin problems?	Yes No
Scotting of rear end?	Yes No	Lumps or bumps?	Yes No
Lameness or stiffness?	Yes No	Tremors or seizures?	Yes No
Listlessness or weakness?	Yes No	Unusual discharge?	Yes No

Has your pet shown **significant change** in any of the following?

Character or bowel movements?	Yes No	Appetite?	Yes No
Frequency or amount of urination?	Yes No	Drinking?	Yes No
Weight gain or loss?	Yes No	Behavior?	Yes No

Anything else we need to know? _____